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ABSTRACT

Two theoretical schools have emerged within the field of communication focusing on the alleviation of dysfunctional communications such as speech anxiety, communication apprehension, and speech reticence. The communication anxiety-behavior therapy school regards excessive anxiety to be a primary factor in dysfunctional communication. This school asserts that anxiety is a learned response susceptible to unlearning, that excessive anxiety during or in anticipation of communication leads to ineffectiveness, that behavior therapy is effective in reducing anxiety, and that communication teachers are qualified to implement such therapy. The speech reticence rhetoritherapy school holds that reticent persons perceive themselves to gain more by remaining silent than by participation. The position of this school is that communication teachers should implement rhetoritherapy programs to treat dysfunctional communication rather than programs to alleviate anxiety since anxiety is not the basis of dysfunctional communication, treating anxiety is the province of psychiatry, eliminating anxiety would also reduce motivation, and rhetoritherapy is a more effective treatment. A practical directive emerging from the perspectives of these two schools is that mass treatment programs without careful individual screening would unduly risk additional failures for troubled persons. (DF)

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RHETORITHERAPY VERSUS BEHAVIOR THERAPY:

ISSUES AND EVIDENCE

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Recently scholars and teachers of communication have devoted increased attention to a set of problems which may be called dysfunctional communication. Dysfunctional communication covers communication which is disrupted by intense affect, especially anxiety, and/or by other difficulties in oral expression which impede an individual's ability to relate to others. Lack of a verbal repertoire to use in social encounters, inability to estimate the perspective of another, and avoidance of interaction are among the problems. As defined here, dysfunctional communication subsumes speech anxiety, communication apprehension, and speech reticence.

Ten years ago, those studying and attempting to treat dysfunctional communication shared a common theoretical base; they believed anxiety was the main cause of dysfunctional communication.[1] Thus efforts at treating the problems emphasized the alleviation of anxiety.[2] More recently, though, another viewpoint has emerged. That viewpoint, referred to here as the speech reticence-rhetoritherapy school perspective, represents a departure from the original speech reticence position and is opposed to anxiety alleviation as a major goal of treatment. Adherents of the other view, called here the communication anxiety school perspective, continue to work from their initial theoretical framework.

So far, the positions of the two schools have not been carefully examined in the communication literature. It is therefore unclear how they differ in theoretical orientation, at what points their claims are in opposition, and in what ways their research findings might be integrated. The purpose here is to examine the positions of the two schools using their rationales for treatment of dysfunctional communication as a focus.

Before proceeding, a preliminary taxonomy of dysfunctional communication problems is needed. The broadest concept is shyness. Shyness has not yet been rigorously defined in the literature, but seems to mean some level or kind of discomfort about communicating. Shyness subsumes two major, more clearly defined dysfunctions, speech reticence which is characterized by the avoidance of interaction, and communication anxiety which refers to a sense of apprehension or fear about communication. At this time, there appear to be two major categories of communication anxiety, general communication anxiety or the fear of all interaction, and specific communication anxiety or fear of specific communication situations like giving a speech (speech anxiety) or meeting a stranger. The familiar rubric, communication apprehension, is equivalent to communication anxiety, a point to be discussed later. Throughout this paper, anxiety will be used principally to denote cognitively experienced fear or dread. Later it will be necessary to redefine the other concepts listed.[3]

Communication Anxiety-Behavior Therapy School

In the field of communication the first school is associated primarily with the work of McCroskey and his colleagues in treating speech anxiety and communication apprehension. Because most of that work is

based on theory and research in behavior therapy, the learning-theory based treatment of affective and communication problems must be included within the parameters of this school.[5]

Implicitly or explicitly the communication anxiety school regards excessive anxiety to be a major if not the primary cause of dysfunctional communication. Thus treament programs focus on alleviating anxiety. The main treatment technique is systematic desensitization,[6] a procedure in which a person learns to relax voluntarily while imagining a threatening situation. Recent interest has also been focused on Cognitive Modification which combines voluntary relaxation with portions of Rational Emotive Therapy.[7] The latter procedure is based on the idea that adverse emotion arises from irrational thinking, so therapy focuses on getting a client to replace irrational thoughts or cognitions with rational ones. For example, a person's anxiety about meeting a stranger may be due to the belief that it is necessary to be admired and liked by everyone. Alleviating anxiety requires that the person convince himself that it is not necessary or even possible to be universally adored.

Both systematic desensitization and Rational Emotive Therapy may be classed as behavior therapy treatments, i.e., they are based on learning theory in opposition to other theories, especially psychoanalytic theory. Within learning theory there are two main conceptualizations of anxiety: as a conditioned response to aversive stimuli or situations and as a learned internal state which mediates between a stimulus (situation) and a response. Systematic desensitization is based on the former, Rational Emotive Therapy on the latter.[8]

Treatment efforts have been directed mainly to problems of speech anxiety and communication apprehension. Although there is general agreement on the meaning of the former, the meaning of the latter requires detailed consideration. According to the most recent statement communication apprehension is, "an individual's level of fear or anxiety associated with real or anticipated (oral) communication with another person or persons."[9] Hence, "The individual suffering . . . is a person for whom apprehension about participating in communication outweighs any projection of gain from communicating. . . . The communication apprehensive individual anticipates negative feelings or outcomes from communication, and thus either avoids communication, if possible, or suffers from a variety of anxiety related feelings while communicating."[10] However, there seems to be limited correspondence between the verbal definition and the operational definition, a score on PRCA (Personal Report of Communication Apprehension) which is the test used in research. As shown by the studies of Burgoon and Daly,[11] PRCA measures fear of communicating but has a low or near-zero correlation with avoidance of communication which communication apprehension is supposed to cover. Communication apprehension should thus be regarded as synonymous with communication anxiety.

By accident the limitation on the meaning of a PRCA score just proposed is a desirable one. Since anxiety and avoidance usually correlate at such a low level, it would inconsistent with empirical data to measure both variables on a single unidimensional scale.

With definitional problems temporarily aside it is possible to set down the position of the communication anxiety school regarding the treatment

of dysfunctional communication. While the rationale has never been fully delineated in the communication literature, the rationale may be satisfactorily inferred from existing articles. In outline form the position seems to read as follows:

> Communication teachers should implement behavior therapy programs directed to alleviating communication anxiety, since
>
> Anxiety is a learned response which can therefore be unlearned;
> Excessive anxiety during or in anticipation of communication causes an individual to be less effective than if the anxiety were reduced;
> Behavior therapy treatments are effective ways to reduce anxiety;
> Communication teachers are qualified to implement behavior therapy programs.

Each argument of the school has merit, yet each requires qualification. To begin, there is little doubt that anxiety responses can be learned, i.e., acquired rather than inborn. Within an elementary classical conditioning paradigm it has been shown that anxiety can be induced,[12] and it has been recently demonstrated that anxiety responses can be acquired vicariously by modeling the behavior of another.[13] The problems with the first argument are theoretical rather than practical: at this point there is no satisfactory explanation for why anxiety reduction procedures work.[14]

The second claim of the communication anxiety school, that excessive anxiety often causes an individual to communicate less effectively, is also fairly easy to substantiate. Although the magnitude of the relationship varies from study to study (often as a function of the measuring instruments employed), internally-experienced anxiety often correlates significantly with overt manifestations of anxiety. In turn, persons who appear anxious tend to be judged less effective than those who appear calm and in control.[15] As is often pointed out in introductory performance texts, some degree of autonomic arousal is necessary for efficient work at any task, but above the optimal arousal level performance suffers. Above optimal arousal may have different, even contradictory effects from one person to another. For some the result may be a speech rate which is too fast, for others too slow. Disruptions in the normal flow of language are among the most common effects. Even though these undesirable effects occur for many, there are clearly other people who report extremely high subjective anxiety but yet do not appear anxious to others. In sum it is clear that high subjective anxiety does negatively affect communication, but the extent of the disruption will vary from person to person--and from observer to observer.

Whether behavior therapies are effective ways of treating dysfunctional communication has been the subject of extensive research. Crucial to the discussion is the meaning of effectiveness. Commonly used criteria are similar to those applied to a new pharmaceutical: it should be safe and generate effects beyond those obtained with a placebo. Almost any kind of treatment will work given a little confidence from those treated and a little credibility from the treatment administrator. Hence it is not adequate for a treatment program merely to produce changes that exceed those found for control subjects. In college and high school programs it should be shown that results are obtained beyond those of taking an ordinary

communication class, and that the results further exceed those that would occur simply as a result of increased attention and expectation.[17]

Methodological problems in determining when a treatment effect exceeds placebo effect have not yet been solved. Even so, in the treatment of speech anxiety systematic desensitization comes closest to meeting the effectiveness criteria; and there is evidence that Rational Emotive Therapy, by itself or combined with relaxation, is equally effective. There is no research to show that other treatments come close to effectiveness.[18]

But for the treatment of other communication dysfunctions, whether general or specific, the picture is much less clear. Systematic desensitization, either alone or combined with Rational Emotive Therapy, is probably not the most likely to work and is certainly less effective than its proponents have sometimes claimed.[19] Numerous behavioral procedures have been tested, among them flooding, overt and covert modeling, and rehersal. Studies comparing the effectiveness of those and other procedures summarily yield only equivocal conclusions about which is most effective for any given dysfunction. However, Eisler's reconcilliation of apparently contradictory findings is worth noting: studies showing the superiority of relaxation-related procedures have mainly used subjects whose problems were less generalized and less severe than studies which show the superiority of skills training programs.[20] With dysfunctions other than speech anxiety, systematic desensitization will probably lead to a reduction of tension, but probably not change an individual's tendency to avoid threatening situations. In the latter case it is doubtful that cognitive modification will prove superior or equal to skills training for serious problems.

A combination of cognitive modification and skills training may well yield the greatest success with the greatest number of persons. In any event, when the problems are severe, behavior therapy procedures are clearly more effective than conventional psychotherapy where the main orientation is gaining insight into why the problem is allegedly present.[21]

The final communication anxiety school argument, that communication teachers are competent to administer behavior therapy anxiety reduction programs, is for now the easiest to deal with. Almost anyone can be trained to administer systematic desensitization or cognitive modification, and level or type of professional training is of little consequence. Even undergraduate peers are successful trainers.[22] But as the earlier discussion shows, the question of who is qualified to recommend a particular procedure for a particular problem is much more puzzling. Also, the technique of flooding, which shows strong promise, requires extensive training to administer because of the chance of negative effects.[23]

By now it should be apparent that there is considerable evidence to support the claims of the communication anxiety school. Yet most of the claims require qualification as will those of the opposing school.

Speech Reticence-Rhetoritherapy School

The second school is associated primarily with the work of Phillips and his colleagues. The theoretical position of the reticence school has recently undergone a major change. Originally anxiety was a central concept. The reticent was defined as "a person for whom anxiety about participation in oral communication outweighs his projection of gain from the situation."[24] The reticent "is so convinced that he is unable to handle what he must handle that he triggers in himself a kind of hypertonic apprehension. He fails at interpersonal communication because he is so fearful of it that he fears his fear."[25]

The current conceptualization of reticent persons omits reference to anxiety: "People who perceive that they can gain more by remaining silent than they can by participation."[26] Speech reticence is a speech disorder shown in a dysfunction of one or more rhetorical subprocesses, "like perceiving a situation in which discourse would be useful . . . or analyzing the persons and the situations of the discourse."[27] Among the common problems are inability to open conversations and to make pertinent remarks in discussions as well as overall avoidance of interaction.

It is not fully clear why the concept of anxiety was abandoned by the reticence school. Initially it was argued that reticents were not fearful or frightened, i.e., did not have a problem focused on a specific situation. Rather reticents were seen as anxious, meaning that their fear pervades all interaction.[28] This interpretation conforms to the traditional psychoanalytic distinction between fear as a situation-specific response and anxiety as a diffuse emotion or free-floating state unrelated to a specific situation. However, the most recent article quotes a description of anxiety and asserts that most reticents do not fit the description.[29] No data are given to support the assertion, and indeed, the assertion seems to be inconsistent with the picture of reticents provided in earlier articles.[30] The present position emphasizes other reasons why communication teachers should not treat anxiety. The position reads as follows:

> Communication teachers should implement rhetoritherapy programs to treat dysfunctional communication rather than programs to alleviate communication anxiety, since
>
> Anxiety is not the basis of dysfunctional communication, since
>
> Asserting that anxiety is the basis of dysfunctional communication presumes a medical model which is not isomorphic with reality, and
>
> Even if anxiety were the basis of dysfunctional communication, it would be wrong for the communication teacher to try to eliminate anxiety, since
>
> Eliminating anxiety reduces motivation, and
>
> Treating anxiety is the province of psychiatry;
>
> Rhetoritherapy is a more effective way to treat dysfunctional communication.

Evaluating the arguments of the reticence school is even more complicated than the earlier discussion suggests. The most recent arguments (above)[31] appear to be an attack on McCroskey's work in implementing large-scale desensitization programs,[32] but no explicit reference is made to McCroskey's major article on the subject. Viewed as assaults on McCroskey's

work the reticence school claims sometimes appear legitimate and sometimes look like attacks on straw men. Due to the ambiguity the following evaluation treats the reticence position as a rebuttal to a behavior therapy orientation to treating dysfunctional communication.

It should be evident that the positions of the two schools are not in exact opposition. Exact opposition is impossible since the definitions of anxiety and its role are neither consistent nor contradictory. Arguing the merits of each definition would require a seperate theoretical paper. Here it will merely be noted that among authorities, the concept of free-floating anxiety is losing ground to the conceptualization of anxiety as the generalization of specific fear responses.[33]

The first argument of the reticence school, that anxiety is not the basis of dysfunctional communication, is an overgeneralization. As shown in the discussion of the communication anxiety school, some dysfunctional communicators are negatively affected by anxiety, but others are not.[34] The percentages are not known at this time.

Whether a medical model is presumed by asserting that anxiety is the basis of dysfunctional communication is perplexing. This subclaim is clearly an attack on writings under the rubric of communication apprehension. The full subclaim reads: "The diagnostic category 'speech apprehensive' presumes a medical model which in turn presumes the existence of some 'norm' for speech communication which is knowable by all. Furthermore it presumes that any deviation from the norm is pathological, and thus, stems from a common cause, shows common symptoms, and has common indications, contra-indications, and prognoses.[35]

Very little in the subclaim above accurately characterizes the communication anxiety school as a whole. True, there are norms for communication anxiety tests, but it cannot be inferred from that fact that all deviations from the norm are considered in any sense pathological.[36] Some high scorers on those tests apparently communicate quite well in nearly every situation. Those individuals probably fall into the category of private shys.[37] They might communicate even more effectively, i.e., be more fluent, appear even more composed, if their anxiety levels were reduced. But they would not necessarily manifest any defect in rhetorical subprocessess and therefore could not be helped through rhetoritherapy as its scope is presently defined. Indeed there are common indications, contraindications, and prognoses for specific kinds of dysfunctional communication problems, but these are not merely presumed. Rather they are inferred from a large body of research findings. Surely the kinds of dysfunctional communication are so varied that it would be absurd for anyone to propose one remedy for all of them.[38]

The second claim of the reticence school badly misrepresents the communication anxiety school orientation. Advocates of behavior therapy procedures are not interested in eliminating anxiety, but rather in reducing it to a reasonable level and bringing it under voluntary control. Certainly there is no basis for the subclaim that eliminating anxiety reduces motivation. Rather the reverse is true: persons treated for specific fears often perform better not only with respect to the problem treated but other areas of life as well.[39] The idea that it is dangerous to eliminate anxiety comes from the notion of symptom substitution in psychoanalytic theory. It was believed that if anxiety were eliminated without resolving the underlying

causative conflict, then the psychic energy would be channeled in some other undesirable way, e.g., reduce fear of strangers and the person may develop a tic or become hostile. Carefully controlled investigations have failed to discover a symptom substitution effect, and thus the concept is of doubtful validity.[40]

Is treating anxiety solely the province of psychiatry? To be fair it must be noted that this claim was inferred rather than stated in reticence school articles. Since much is made of the fact that reticents do not fit psychiatric definitions of anxiety, and since it is noted that the appropriate treatment for speech anxiety is pharmacological,[41] the claim was written as it appears here. As noted earlier, a wide range of persons can be trained simply to help others alleviate anxiety, and it is unclear why psychiatry should be the focal profession. There are no intellectual or moral grounds for summarily excluding others. Legal questions at this time are unanswerable since it is unclear how teaching or training differ from therapy or counseling.

Assessing the effectiveness of rhetoritherapy must wait for published data. Even so, evidence presented earlier in this paper clearly shows that skills training should definitely be included in any program for chronic communication avoiders. The use of interpersonal skills training along with rehersal is common to both schools.

Conclusion

At this time research in treating dysfunctional communication is a potpourri of findings which almost elude synthesis. For instance, comunication anxiety is sometimes inferred (incorrectly) from avoidance, and measures from different domains (e.g., physiological, self-report, observational) often produce contradictory findings. But the findings do indicate that as an emotional variable affecting communication, anxiety has been overrated. Sometimes avoiding communication is a way of hurting others who expected communication. In those cases the emotional basis of the dysfunction is not anxiety but anger. The importance of depression is also overlooked. Costello argues that a sense of hopelessness is associated with depression rather than with anxiety.[42] Thus avoiding communication may have little to do with fear of rejection or failure but rather with a sense that nothing will come of the effort. Emotional responses are often mixed and it has been contended that anxiety itself never occurs without involvement of another emotion.[43] Reconceptualization of both the nature of the problems and of the treatment process are obviously in order. Neither of the schools examined here can be said to have the preponderance of evidence on its side.

One firm practical directive emerges from the material covered in this paper: mass treatment programs without careful individual screening are to be discouraged. Not to screen carefully is to risk additional failures for troubled persons. No guarantee of success can be made even with the best screening, but conscientiously trying to fit the treatment to the problem will reduce the risks. Using a score from a single pencil-and-paper test is clearly unsatisfactory because of measurement error and validity problems. There are far too many methodological difficulties and far too little treatment data to claim success without risk at this time.

In many ways there is similarity between the overall positions of the two schools--much more than might be supposed. What occurs under the rubric of teaching in the rhetoritherapy school is often identical with practices which the communication anxiety school calls therapy. The use of goal analysis and the formulation of behavioral objectives is shared and so is interest in using multiple treatment approaches. Another strong tie is the idea of negotiation between teacher/therapist and student/client.

While much research and theory building obviously remain, in the long run it will probably prove inconsequential whether treatment proceeds from a pedagogical model or a therapeutic model. Those models are more often complementary than at variance. More important is the fact that the communication profession is finally free of the simple-minded and often punitive model that asserts that all a dysfunctional communicator needs is a kick in the seat and a pat on the head--though is still needed occasionally.
Reach

Footnotes

[1]Gerald M. Phillips, "Reticence: Pathology of the Normal Speaker," Speech Monographs, 35 (1968), 39-49; James C. McCroskey, "Measures of Communication-Bound Anxiety," Speech Monographs, 37 (1970), 269-77.

[2]James C. McCroskey, David C. Ralph, and James E. Barrick, "The Effect of Systematic Desensitization on Speech Anxiety," Speech Teacher, 19 (1970), 32-36.

[3]Taken together, the following support this classification: Judee K. Burgoon, "The Unwillingness to Communicate Scale," Communication Monographs, 43 (1976), 60-69; John A. Daly, "The Assessment of Social-Communicative Anxiety Via Self-Reports," Communication Monographs, 45 (1978) 204-18; David Watson and Ronald Friend, "Measurement of Social-Evaluative Anxiety," Journal of Consulting and Clinical Psychology, 33 (1969), 448-57; Philip G. Zimbardo, Shyness, (Reading, Ma.: Addison-Wesley, 1977).

[4]McCroskey, Ralph, and Barrick; James C. McCroskey, "The Implementation of a Large Scale Program of Systematic Desensitization for Communication Apprehension," Speech Teacher, 21 (1972), 255-64.

[5]For an overview of behavior therapy, see K. Daniel O'Leary and G. Terrence Wilson, Behavior Therapy, (Englewood Cliffs, N.J.: Prentice-Hall, 1975).

[6]Joseph Wolpe, Psychotherapy by Reciprocal Inhibition (Stanford, Ca.: Stanford Univ. Press, 1958.

[7]Michael Weissberg, "Anxiety-Inhibiting Statements and Relaxation Combined in Two Cases of Speech Anxiety," Journal of Behavior Therapy and Experimental Psychiatry, 6 (1975), 163-64; Albert Ellis, Reason and Emotion in Psychotherapy (New York: Lyle Stuart, 1962).

[8]John R. Lick and Edward S. Katkin, "Assessment of Anxiety and Fear," in Michael Hersen and Alan S. Bellack, Behavioral Assessment (Elmsford, N.Y.: Pergamon, 1976), 177-79.

[9]James C. McCroskey, "Validity of the PRCA as an Index of Oral Communication Apprehension," Communication Monographs, 45 (1978), p. 192.

[10]James C. McCroskey and Lawrence R. Wheeless, Introduction to Human Communication (Boston: Allyn and Bacon, 1976), 80-81.

[11]Supra, n. 3. Existing data clearly show that communication avoidance cannot be considered the extreme case of communication anxiety. Neither can anxiety as a subjective state of distress be inferred from avoidance. As used here communication anxiety is not synonymous with social anxiety, for social anxiety is often used in psychological journals to include both anxiety and avoidance or to mean simply avoidance.

[12]O'Leary and Wilson, p. 68

[13]Steffan Hygge and Arne Ohman, "Modeling Processes in the Acquisition of Fears," Journal of Personality and Social Psychology, 36 (1978), 271-79.

[14]See, for example, Gordon L. Paul, Insight versus Desensitization in Psychotherapy (Stanford, Ca.: Stanford Univ. Press, 1966).

[15]A. Robert Sherman, Anthony Mulac, and Michael J. McCann, "Synergistic Effect of Self-Relaxation and Rehersal Feedback in the Treatment of Subjective and Behavioral Dimensions of Speech Anxiety," Journal of Consulting and Clinical Psychology, 42 (1974), 819-27; McCroskey, "Validity. . . ."

[16]Anthony Mulac and A. Robert Sherman, "Behavioral Assessment of Speech Anxiety," Quarterly Journal of Speech, 60 (1974), 134-43; David C. Murray, Talk, "Silence, and Anxiety," Psychological Bulletin, 75 (1971), 244-60; Stanislav V. Kasl and George F. Mahl, "Relationship of Disturbances and Hesitations in Spontaneous Speech to Anxiety," Journal of Personality and Social Psychology, 1 (1965), 425-33.

[17]For a discussion of these problems, see James Lick and Richard Bootzin, "Expectancy Factors in the Treatment of Fear," Psychological Bulletin, 82 (1975), 917-31; William T. Page, "Recent Research in the Treatment of Speech Anxiety," paper presented at the 1978 ICA Convention in Chicago; Andrew Mathews, "Fear Reduction and Clinical Phobias," Psychological Bulletin, 85 (1978), 390-404.

[18]Page.

[19]James P. Curran and Francis S. Gilbert, "A Test of the Relative Effectiveness of a Systematic Desensitization Program and an Interpersonal Skills Training Program with Date Anxious Subjects," Behavior Therapy, 6 (1975), 510-21; J. C. Wright, "A Comparison of Systematic Desensitization and Social Skill Acquisition in the Modification of a Social Fear," Behavior Therapy, 7 (1976), 205-10; Cyril M. Franks and G. Terrence Wilson, "Systematic Desensitization, Flooding, Symbolic Modeling, Cognitive Restructuring, and Assertion Training, in Annual Review of Behavior Therapy, Vol. 4 (New York: Brunner/Mazel, 1976), 119-49.

[20]Richard M. Eisler, "Behavioral Assessment of Social Skills," in Hersen and Bellack, pp. 371-72.

[21]Paul.

[22]McCroskey, Ralph, and Barrick, "Effect . . ."; William J. Fremouw and Morton G. Harmatz, "A Helper Model for Behavioral Treatment of Speech Anxiety," Journal of Consulting and Clinical Psychology, 43 (1975), 652-60.

[23]K. P. Morganstern, "Implosive Therapy and Flooding," Psychological Bulletin, 79 (1973), 318-34.

[24]Phillips, "Reticence . . . ", p. 40.

[25]Gerald Phillips, David E. Butt, and Nancy J. Metzger, Communication in Education (New York: Holt, Rinehart and Winston, 1974), p. 177.

[26]Gerald M. Phillips, "Rhetoritherapy Versus the Medical Model," Communication Education, 26 (1977), 37-8.

[27]Kent A. Sokoloff and Gerald M. Phillips, "A Refinement of the Concept of Reticence," Journal of Communication Disorders, 9 (1976), p. 331. This article contains the fullest and clearest exposition of reticence.

[28]Gerald M. Phillips and Nancy J. Metzger, "The Reticent Syndrome," Speech Monographs, 40 (1973), 220-30.

[29]Phillips, "Rhetoritherapy . . .", p. 36.
[30]Ibid., p. 41.
[31]Ibid.
[32]McCroskey, Ralph, and Barrick, "Implementation. . .".
[33]Aaron T. Beck, Cognitive Therapy and the Emotional Disorders (New York: International Universities Press, 1976); C. D. Spielberger, "Theory and Research on Anxiety," in C. D. Spielberger (Ed.), Anxiety and Behavior (New York: Academic Press, 1966), 3-20.
[34]Paul A. Pilkonis, "Shyness, Public and Private, and its Relationship to Other Measures of Social Behavior," Journal of Personality, 45 (1977), 585-95.
[35]Phillips, "Rhetoritherapy . . .", p. 36.
[36]McCroskey, Ralph, and Barrick ("Implementation . . .") were incorrect in asserting that persons scoring at some stipulated level on PRCA were necessarily in need of systematic desensitization.
[37]Pilkonis.
[38]Attempting to fit the communication anxiety school to a medical model comes close to attacking a straw man. Actually the communication anxiety school is in opposition to the medical or disease model of behavioral and emotional disturbance. See D. A. Begelman, "Behavioral Classification," in Hersen and Bellack, pp. 23-48.
[39]Gordon L. Paul, "Insight versus Desensitization in Psychotherapy Two Years after Termination," Journal of Consulting Psychology, 31 (1967), 333-48; "Two-Year Followup of Systematic Desensitization in Therapy Groups," Journal of Abnormal Psychology, 73 (1968), 119-30.
[40]O'Leary and Wilson, pp. 447-8.
[41]In the most recent article (Phillips, "Reticence . . .", p. 36) it is noted that for stage fright the appropriate treatment would usually be pharmacological which would naturally place treatment in the province of psychiatry. However, the footnoted reference (p. 36, n. 7) is irrelevant to the assertion. In Sokoloff and Phillips persons who have trouble with anxiety are alleged to need psychotherapy, and no mention is made of pharmacological treatment. There is no apparent reason for the change in orientation.
[42]Charles G. Costello, Anxiety and Depression (Montreal and London: McGill-Queen's University Press, 1976).
[43]Carroll E. Izard, "Anxiety," in C. D. Spielberger (Ed.) Anxiety, 2 Vols. (New York: Academic Press, 1972), 51-106.